

FA1264

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
FILED

95 JAN 26 AM 9:06

JAN 26 1995

95004532

STATE OF INDIANA)
COUNTY OF MONROE)

SS: MARGARETTE N. CLEVELAND
LAKE COUNTY RECORDER

SAM ORLICH
AUDITOR LAKE COUNTY

HOLD FOR FIRST AMERICAN TITLE

AFFIDAVIT

Jacqueline K. Harrison, after first being duly sworn upon oath for the purpose of inducing First American Title Insurance Company to issue its Title Insurance Policy Commitment number FA14264 covering the real estate described in said Commitment, deposes and says:

1. That she resides in Monroe County, Indiana at 635 Robin Drive, Ellettsville, Indiana.

2. That she is one of two children born to Kathryne V. Carpenter and Adelbert L. Carpenter, and that neither of her parents at anytime adopted any child or children.

3. That Affiant's mother, Kathryne V. Carpenter, died on the 30th day of January, 1980, a resident of Lake County, Indiana, as evidenced by a copy of a Medical Certificate of Death attached hereto.

4. That said decedent at the time of her death was one of the owners of the real estate described in said Title Commitment and at the time of her death owned no other property which would be subject to succession taxes, state inheritance taxes or federal estate taxes.

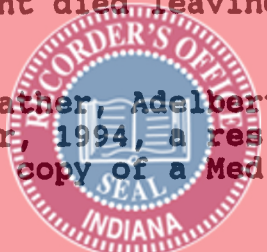
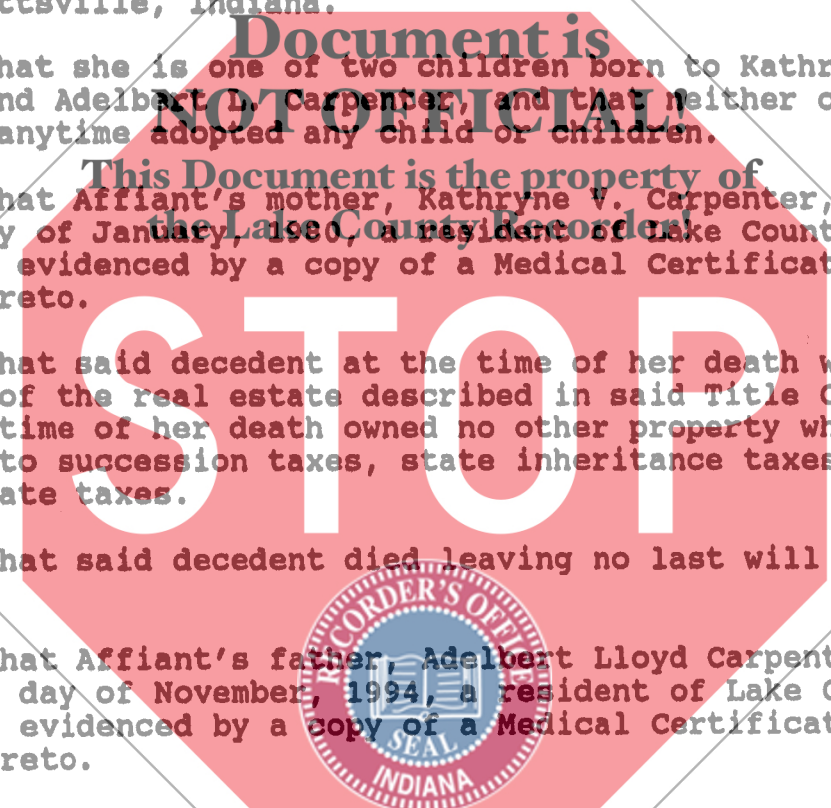
5. That said decedent died leaving no last will and testament.

6. That Affiant's father, Adelbert Lloyd Carpenter, died on the 28th day of November, 1994, a resident of Lake County, Indiana, as evidenced by a copy of a Medical Certificate of Death attached hereto.

7. That at the time of the death of Adelbert L. Carpenter, he was the owner of property described in said Title Commitment.

8. That said Adelbert L. Carpenter died leaving a Last Will and Testament which is admitted to probate before the Lake Circuit Court in the matter of the estate of Adelbert Lloyd Carpenter, deceased, Cause Number 45C01 9412 EU 387.

9. That Affiant and her only other sibling, Karen L. Nolcheff, are in the exclusive possession of the real estate described in said Title Commitment and no other person or persons has made claim thereto.



001122

Handwritten initials and date: H21 1/26/95 ja

Further Affiant sayeth not.

Jacqueline K. Harrison
Jacqueline K. Harrison

STATE OF INDIANA)
) SS:
COUNTY OF MONROE)

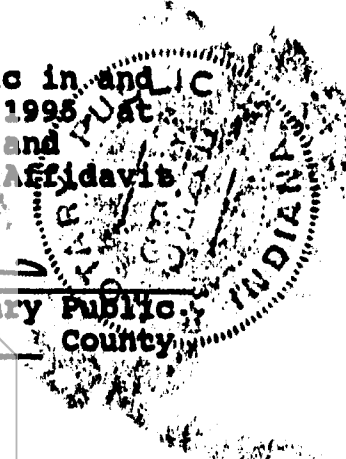
Subscribed and sworn to before me, a Notary Public in and for said county and state, this 16th day of January, 1995, at which time Jacqueline K. Harrison personally appeared and acknowledged the execution of the above and foregoing Affidavit to be a voluntary act and deed.

My Commission Expires:

10/20/98

**Document is the property of Notary Public.
NOT OFFICIAL!**

~~This Document is the property of Notary Public,
A Resident of Monroe County,
the Lake County Recorder!~~



This Instrument Prepared By
RICHARD S. HARRISON, ATTORNEY AT LAW
ANDREWS, HARRELL, MANN, CHAPMAN & COYNE P.C.
528 N. Walnut St., P.O. Box 2478
Bloomington, Indiana 47402-2478
Telephone: (812) 332-6556

LOTS 27 AND 28, BLOCK 4 IN FIRST SUBDIVISION OF EAST GARY, IN THE CITY OF LAKE STATION, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 7 PAGE 9, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.



**Document is
NOT OFFICIAL!**

**This Document is the property of
the Lake County Recorder!**

STOP



**LAKE COUNTY HEALTH DEPT.
VETERINARY INSURANCE
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.**

[Handwritten Signature]
HEALTH OFFICER

THIS DOCUMENT NOT VALID UNLESS STAMPED ON REVERSE SIDE

PORTER COUNTY BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

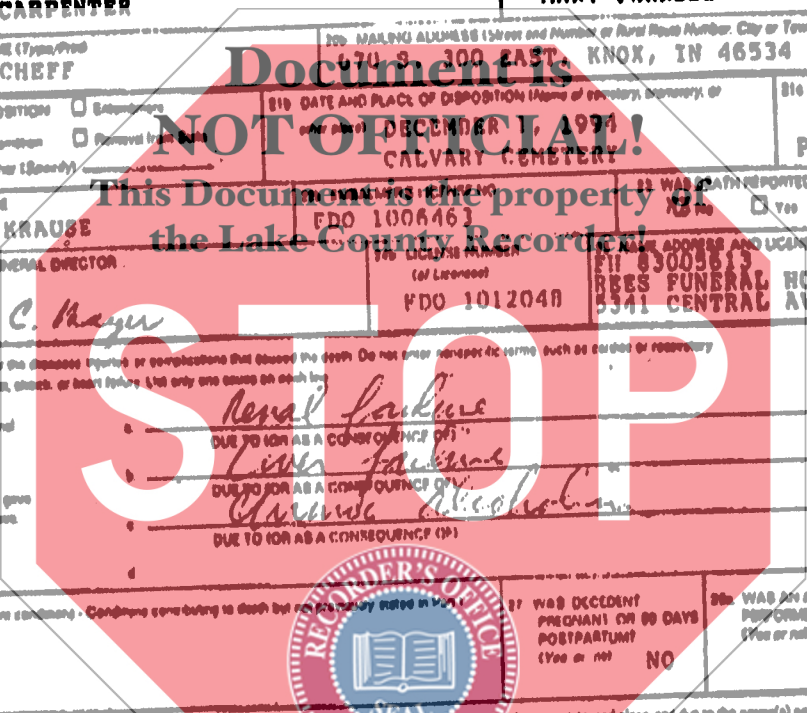
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (Use Middle Last) ADELBERT L. CARPENTER		2 SEX MALE	3a TIME OF DEATH 10:15PM	3b DATE OF DEATH (Month Day Year) NOVEMBER 28, 1994
4 FEDERAL SECURITY NUMBER 311-18-9270	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days Years Months	6 DATE OF BIRTH (Month Day Year) APRIL 29, 1921	7 BIRTHPLACE (City and State or Foreign Country) JOLIET, ILLINOIS
8a WAS DECEDENT A US VETERAN? YES	8b YEAR LAST SERVED IN US ARMY / FORECAST 1945	9 PLACE OF DEATH (Specify only one building) HOSPITAL <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		
10 FACILITY NAME (If not institution give street and number) MILLER'S HERRY MANOR		11 CITY TOWN OR LOCATION OF DEATH PORTAGE		12 COUNTY OF DEATH PORTER
13 MARITAL STATUS (Specify) WIDOWED	14 SURVIVING SPOUSE (If wife give maiden name) N/A	15 DECEDENT'S USUAL OCCUPATION (Give kind of work and specify kind of working life. Do not use retired) ACCOUNTING CLERK		16 NAME OF BUSINESS/INDUSTRY BUDD COMPANY
17a RESIDENCE—STATE INDIANA	17b COUNTY LAKE	17c CITY TOWN OR LOCATION LAKE STATION		
18a ZIP CODE 46405		18b STREET AND NUMBER 2747 DEARBORN STREET		
19a INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	19b ON A FARM? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	19c CITIZEN OF WHAT COUNTRY? USA	19d WOULD DECEDENT (IF NEARANCE (NON-RESIDENT)) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	19e RACE—American Indian (Specify) WHITE
19f DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 		19g MOTHER'S NAME (First Middle Maiden Surname) MARY PARRELL		
20 FATHER'S NAME (First Middle Last) CLARENCE CARPENTER		21a MARITAL ALIENAGE (State and Number or Rural Route Number, City or Town, State, Zip Code) 674 S. 300 EAST, KNOX, IN 46534		21b Relationship DAUGHTER
22 INFORMANT'S NAME (Type, Print) KAREN NOLCHEFF		23 DATE AND PLACE OF DISPOSITION (Name of cemetery, burying, or other place) DECEMBER 1, 1994 CALVARY CEMETERY		
24 METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal to another place <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		25 LOCATION—City or Town, State PORTAGE, INDIANA 46368		
26a EMBALMER'S NAME JAMES J. KRAUSE		26b WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
27 SIGNATURE OF FUNERAL DIRECTOR <i>David C. Meyer</i>		28 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME BEES FUNERAL HOME, OLSON CHAPEL 5341 CENTRAL AVE., PORTAGE, IN 46368		
29 PART I: State the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Renal failure LIVER FAILURE Chronic Alcoholism		29a IMMEDIATE CAUSE (Final disease or condition resulting in death) Renal failure		
29b CONDITION, if any, which gave rise to the immediate cause during the underlying disease list LIVER FAILURE		29c DUE TO (OR AS A CONSEQUENCE OF) Chronic Alcoholism		
30 PART II: Other significant conditions - Conditions contributing to death but not primary cause in Part I		31 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	32 WAS AN AUTOPEY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	33 WERE AUTOPEY PHOTOS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
34 CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of a coroner's report or on the basis of my own death natural at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of a coroner's report or investigation, my opinion death occurred at the time, date and place, and due to the cause(s) as stated.		35 SIGNATURE AND TITLE OF CERTIFIER <i>Donald J. Madduck</i>		
36 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29) (Type, Print) DONALD J. MADDUCK, 3125 WILLOWCREEK ROAD, PORTAGE, INDIANA 46368		37 MEDICAL LICENSE NO. U2001180	38 DATE SIGNED (Month Day Year) 11-30-94	
39 HEALTH OFFICER'S SIGNATURE <i>Sam A. Balogh</i>		40 DATE FILED (Month Day Year) November 30, 1994		
41 MANNER OF INJURY <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		42 DATE OF INJURY (Month Day Year)	43 TIME OF INJURY	44 HEALTHY AT WORK? (Yes or no)
45 PLACE OF INJURY—At home from work factory office building etc. (Specify)		46 DESCRIBE HOW INJURY OCCURRED		
47 DATE PHONOUNCED DEAD (Month Day Year)		48 MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		



[Handwritten signature]

